

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010002  
STATE FILE NUMBER

FILED MAR 31 1959 Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 52

1. PLACE OF DEATH a. COUNTY <i>Laclede</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Laclede</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Lebanon</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Lebanon Rural</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Wallace Hosp.</i>		Length of stay in lb <i>2 days</i>	d. STREET ADDRESS (If outside, give location) <i>R.R. # 2</i> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles Oscar Welch</i>			4. DATE OF DEATH Month Day Year <i>March 26, 1959</i>		
--	--	--	---	--	--

5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 29, 1878</i>	9. AGE (In years last birthday) <i>80</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (City and state or country) <i>Illinois</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
--	--	---	---

13a. FATHER'S NAME <i>William W. Welch</i>	13b. MOTHER'S MAIDEN NAME <i>Laura V. Tracy</i>	14. NAME OF HUSBAND OR WIFE <i>Lena</i>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mrs. Lena Welch</i>	Address <i>Lebanon Mo</i>
--	--	---	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertrophy prostate</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>610X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
---

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--

21. I attended the deceased from Death occurred at <i>Apr 4 1956</i> to <i>Mar 26 1959</i> and last saw her alive on <i>Mar 26 1959</i> <i>5:30 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>J. H. Johnson</i> (Degree or title) <i>M.D.</i>	22b. ADDRESS <i>Lebanon, Mo.</i>	22c. DATE SIGNED <i>3-27-59</i>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>3/29/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Datson Cemetery near Lebanon, Mo.</i>	23d. LOCATION (City, town, or county) (State)
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <i>Dorsey M. Howe</i> ADDRESS <i>Lebanon Mo</i>	25. DATE RECD. BY LOCAL REG. <i>3-27-1959</i>	26. REGISTRAR'S SIGNATURE <i>Hella B. Hlay</i>
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Cause, habit, etc. must use only standard nomenclature in item 16. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Dorsey M. Howe*  
Licensed Embalmer No. *4222*  
P. O. Address *Lebanon, N*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.